

Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 6 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name		First Name		AHCCCS ID		D.O.B.		Age (Years)	
Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name			

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL

Comments

NUTRITIONAL ASSESSMENT [] Adequate [] Inadequate [] Referred

SENSORY SCREEN Vision: Within normal limits? [] Yes [] No, Refer

Hearing: Within normal limits? [] Yes [] No, Refer

Speech: Within normal limits? [] Yes [] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [] Yes [] No

(If suspicious, do specific objective testing) Assessment Tool (name)

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [] Yes [] No

Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.)

T _____

P _____

R _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed?

[] Yes [] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today?

[] Yes [] No

Is there a current immunization record in the medical chart?

[] Yes [] No

ANTICIPATORY GUIDANCE

- [] Good health habits
- [] Social interactions
- [] Good parenting practices
- [] Bicycle helmet

- [] Safety
- [] Dental Care
- [] Nutrition

REFERRALS

- [] Dental
- [] Behavioral Health _____
- [] CRS
- [] Specialty _____
- [] Other

Next scheduled visit

Clinician Name

Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)?

[] Yes

[] No